LONG COUNTY SCHOOL SYSTEM
Special Education Department
Background Information
(To be completed by parents or guardian)

Dear Parent: We would appreciate your help in completing this information regarding your child and returning it to the school. The information will help us in working more effectively with your child. Information on this form will be treated in a confidential manner.

Child's Name: ____ Date today: _________
First *Middle* *Last*

Address: ____ Birthdate:__________

Name of parent or guardian with whom child lives: ____________________________ Home Phone #: __________

Agencies or specialists that have worked with this child or family:
Mental Health Clinic _____ Family Physician _____ Social Worker _____ Other _____

If any checked, please give the following information:

NAME	TITLE	ADDRESS	DATE SEEN
___________________	_________	_________________________	__________
___________________	_________	_________________________	__________

FAMILY DATA

Mother's Name: ______________________________ Age: _______ Education: (optional) ___________

Place of Work ______________________________ Work Phone Number: _____________________

Father's Name: ______________________________ Age: _______ Education: (optional) ___________

Place of Work ______________________________ Work Phone Number: _____________________

Step-Parent's Name: ___________________________ Age: _______ Education: (optional) ___________

Place of Work ______________________________ Work Phone Number: _____________________

Marital Status of Parents: ____

If parents are separated or divorced, how old was child when the separation occurred? ___________________

List all people living in household:

Name:	*Relationship to Child*	*Age*
______________________________	_________________________	__________
______________________________	_________________________	__________
______________________________	_________________________	__________
______________________________	_________________________	__________
______________________________	_________________________	__________

If any brothers or sisters are living outside the home, list their names and ages:

Name	*Age*
______________________________	__________
______________________________	__________
______________________________	__________

Did your child attend preschool? If so, name of Pre-K program: ____

SCHOOL HISTORY

Number of years attended this school (circle one): 1 2 3 4 5 6 7 8

Grades Repeated: ____

Other Schools Attended: ____
____

Describe any serious problems your child has had at school: ____
____

Describe any serious problems your child has had at home: ____
____

BIRTH HISTORY

List any illnesses or problems occurring during pregnancy. ____
____

Full Term: Yes No Birth weight: __________________

Delivery: *Normal Breech Cesarean* *Complications:* ________________________
____

Was there any evidence of injury at birth? Yes No Explain: ____

Were any of the following experienced before the child's fifth birthday? ____Ear Infections ____Convulsions

Other: ____ ____Serious Accidents ____Head Injuries

Please give additional information on any item checked above: ____
____
____

DEVELOPMENTAL DATA

At what age did the following behaviors first occur?

______Crawled
______Sat alone
______Walked alone
______Said first words besides "Ma-Ma" and "Da-Da"
______Speech was clearly understood by others outside the family

______Toilet trained during day
______Toilet trained during night
______Tied shoes
______Dressed self
______Slept alone

PHYSICAL CONDITION

My child's general condition is:

Seems to be in good health	Tires easily, listless, lacks energy
Overweight	Sleeps too much
Underweight	Sleeps too little
Overly active; always on the move	Awkward in running, walking, or playing

List any physical handicaps, serious illnesses, hospital stays, accidents or head injuries (vision, hearing, speech, seizures, operations, diseases, etc. ____

____

____

____

____

Is your child on any prescription medication? Yes No If so, what? ______________________________

____

____

Physician's name: ____

BEHAVIORAL CHECKLIST

(Please check the behaviors that best describe your child)

____Feels happy with him/herself	____Sucks his/her thumb	____Wets the bed
____Demands excessive attention	____Overly dependent on others	____Cries often
____Plays well with other students	____Overly anxious to please	____Poor self-control
____Exhibits uncooperative attitude	____Tries to control others	____Friendly
____Has very few close friends	____Relates well to adults	____Sad or depressed often
____Lacks motivation, lazy	____Aggressive	____Shy, withdrawn
____Does not adjust readily to change	____Fearful	____Daydreams often
____Acts younger than other children his/her age	____Openly affectionate to family members	____Easily frustrated
____Can be trusted	____Restless	____Jealous of brother(s)sister(s)
____Loud		

If you wish to add additional information, please add it below or attach to this form. Thank you for your input.

____ __________________________

Parent/Guardian's Signature *Date*